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No. 92-1813

In The

Supreme Court of the United States

October Term, 1992

FHP, INC.,

Petitioner,

v.

ADA SOLORZANO, AMERICA RODRIGUEZ and DOLORES MORALES, in their individual capacities and for the general public,

Respondents.

Petition For Writ Of Certiorari To The California Court Of Appeal, Second Appellate District, Division One

REPLY BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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THE ISSUES PRESENTED IN THE PETITION FOR CERTIORARI ARE OF VITAL IMPORTANCE DIRECTLY AFFECTING THE RENDITION OF MEDICAL CARE TO 1.6 MILLION MEDICARE BENEFICIARIES AND PLAINTIFFS HAVE PRESENTED NO VALID GROUNDS FOR DECLINING REVIEW.

A. Preemption Of Private, Ad Hoc Attempts To Create A Regulatory Scheme Governing HMO Participation In Medicare Via State Court Injunctive Relief In No Way Affects The Ability Of State Authorities To Provide Redress For Fraud Or Oversee The Medicaid Program.

In an effort to avoid review by this Court, plaintiffs mischaracterize the arguments presented in the petition and assert broad, unsupported propositions that have little to do with the instant case. First, plaintiffs argue in conclusory fashion that finding preemption of their state court action for injunctive relief with respect to the manner in which FHP participates in the Medicare contracting program would somehow impair the ability of states to provide redress for fraud committed by HMOs who incidentally also participate in Medicare. Opp., p. 2. Plaintiffs do not, however, explain *how* this is so. FHP has not, at any point, argued that plaintiffs' individual causes of action for personal injury damages are preempted. Rather, FHP has focused solely upon the claims for injunctive relief which directly seek to regulate the manner in which FHP (and indeed other HMOs) participate in the Medicare program, including the core question of whether they must refund, or will be entitled to retain, Medicare reimbursement.

It is precisely because claims for injunctive relief are uniquely intrusive that they are subject to preemption – a personal injury judgment in a single case or even several cases, while it may have an indirect impact on the means

by which a federally regulated business conducts operations, lacks the pervasive impact of a full blown regulatory scheme. This Court's decisions in *English v. General Electric Co.*, 110 S. Ct. 2270, 2278-2279 (1990) and *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 249-251 (1984) underscore this point. While the Court in each case concluded that individual personal injury actions for damages were not preempted by federal regulation of the nuclear power industry, the Court reaffirmed the principle that direct regulation of the industry remained subject to sole federal control. Can it seriously be contended that had the individual plaintiffs in *English* and *Silkwood* added claims for injunctive relief seeking to regulate the specific manner in which a plant operated, i.e., safety levels, frequency of inspection, etc., the Court would not have found the regulation by injunction to be preempted? Preemption is mandated because an informal regulatory scheme imposed by private litigants through injunction is every bit as invasive as a legislatively enacted regulatory scheme. Just as a state legislature would be foreclosed from enacting a statute prohibiting an HMO's participation in Medicare as a sanction for purported misconduct under state law, so, too, are private litigants barred from achieving the same ends via injunction.

Plaintiffs' assertion that a finding of preemption would impact the ability of the states to regulate *Medicaid* providers who also incidentally provide services to Medicare beneficiaries is similarly unfounded. Indeed, if there is anything that is "incidental," it is plaintiffs' status as Medicaid recipients. As the allegations of plaintiffs' complaint make clear, FHP provided services to them pursuant to a contract executed between Medicare and FHP. The complaint conspicuously does *not* allege that FHP provided care to the plaintiffs pursuant to a Medi-Cal/

Medicaid contract.[1] The states remain free to regulate HMOs that provide services to Medicaid beneficiaries, pursuant to a Medicaid contract. However, Medicaid participation is not at issue in the instant case.

What plaintiffs are essentially doing is attempting to obtain redress for a private action for fraud by extending injunctive relief to the defendant's participation in a federal program. While state law may grant a plaintiff many remedies, most particularly damages, it surely does not have the power to unilaterally affect the manner in which an HMO participates in a purely federal program and receives federal funds.

A finding of preemption will in no way impact the ability of plaintiffs to receive redress under state law for their individual damage claims nor impair the means or manner by which the states may regulate Medicaid providers.

B. The Petition Raises Issues Of Vital Importance To The Provision Of Health Care To 1.6 Million Medicare Beneficiaries Throughout The Country And 600,000 Medicare Beneficiaries In California Alone, And Directly Impacts Future HMO Participation In Medicare.

Plaintiffs assert that review is unwarranted because as of yet there is no conflict among the federal courts or state courts with respect to the power of private litigants to bring a state court action for injunctive relief seeking to regulate the manner in which an HMO participates in Medicare. As a threshold matter, the absence of cases in

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[1] In fact, plaintiffs' lawsuit is premised on the allegation that FHP was *not* a Medicaid provider, i.e., that its employees falsely represented that the Senior Plan was affiliated with Medicaid. See Opp. to Petition, p. 4.

this regard simply underscores the truly extraordinary and indeed unprecedented incursion into a purely federal program that the actions of the California courts represent here. Research has disclosed no similar case where private litigants, invoking state law, have attempted to bring an ad hoc action for injunctive relief essentially attempting to create out of whole cloth a regulatory scheme governing an entity's participation in a federal program and indeed exercise direct control over disbursement of federal funds. If anything, this dramatic departure from the strict limitations on state power mandates review by this Court.

This is not an isolated case involving only a few plaintiffs or a small industry. As noted in the petition, 600,000 Medicare beneficiaries are enrolled in HMOs in California alone, and a total of 1.6 million are enrolled across the country. It is of overwhelming importance to HMOs to know with certainty precisely who sets the guidelines for participation in a Medicare approved contract and, most critically, who possesses final power as to payment or retention of Medicare reimbursement under these contracts – particularly in California, the largest single market for such contracts. The federal government is directly encouraging Medicare beneficiaries to enroll in HMOs and, in turn, HMOs to contract with the federal government to provide services to those beneficiaries. To accomplish this, the federal government has created specific guidelines to streamline administration of the program and, more critically, resolve differences concerning compliance with standards and payment of reimbursement. This substantial federal interest in uniformity with respect to the manner in which HMOs participate in Medicare and the standards by which Medicare reimbursement decisions are made is directly disrupted

by the ad hoc claim for injunctive relief urged by plaintiffs here.

This case clearly presents issues of constitutional magnitude in an area of paramount federal importance – the provision of health care services to Medicare beneficiaries in a cost efficient and effective manner. In a time when perhaps the most grave issue to be confronted in the country is the provision of health care to the public at large and to Medicare beneficiaries in particular, it is vital that this Court grant review to provide firm guidelines concerning private regulation of the federal Medicare program in general, and HMO participation in particular.

C. The Legislative History Of The Medicare Statutes Makes It Clear That Congress Did Not Intend Private Litigants To Maintain A State Law Action For Injunctive Relief Regulating The Manner In Which HMOs Participate In Medicare Or Determining Entitlement To Medicare Reimbursement.

In asserting that Congress intended private litigants to bring a state court action for injunctive relief concerning the manner in which HMOs participate in Medicare and receive reimbursement for rendering services to Medicare beneficiaries, plaintiffs cite the general rule that preemption is not to be lightly inferred and point to HCFA's "formal" statement that HMOs are required to comply with local marketing standards. Conspicuously, however, plaintiffs fail to come to grips with the glaring dichotomy between the Medicare and Medicaid programs. In Medicaid, Congress expressly created joint federal-state enforcement mechanisms. Yet, Medicare contains no similar joint enforcement scheme. To the contrary, all remedies reside in the Secretary. This makes perfect sense since, of course, Medicare, unlike Medicaid, involves solely federal funds. It is entirely logical that

Congress would assume that the federal government would exercise direct control over payment of federal funds in a purely federal program.

Moreover, as to HCFA's statement that HMOs are to comply with local marketing requirements, as noted in the petition this, at most, indicates HCFA incorporation or adoption of state standards. It does not suggest that states have independent power to regulate the manner in which HMOs solicit, enroll and receive reimbursement for providing services to Medicare beneficiaries. This point is made plain by the fact that HCFA found it necessary to specifically state its position in this regard – the assumption being that absent this statement, HMOs would have no reason to look to state law to determine compliance with HMO marketing standards.

More significantly, plaintiffs ignore the fact that whatever HCFA's attitude is towards coordination with *state agencies* concerning review of HMO marketing procedures and enforcement of standards, no such coordination or uniformity is possible with respect to the ad hoc unilateral claims for injunctive relief that they are asserting here. Plaintiffs, tellingly, can point to no legislative history, statement of policy by HCFA, or the like, which even remotely suggests that Congress or the federal agency in any way envisioned, much less condoned, private state court actions for injunctive relief that essentially attempt to create an ad hoc regulatory scheme governing HMO participation in Medicare and, more specifically, direct control over disbursement over federal funds.

If anything, review of the pertinent statutes, i.e., 1395mm, et seq., and federal law as a whole, repudiates such individual, free-wheeling attempts to regulate the operation of a federal program. Indeed, as noted in the petition, plaintiffs' position is untenable when viewed in

light of the False Claims Act, 31 U.S.C. sections 3729-3730, which confine private rights of actions concerning disbursement of federal funds and operation of federal programs to limited circumstances. The considerable protections afforded the federal interest in the context of a qui tam action under the False Claims Act are notably absent from the state court action for injunctive relief asserted by plaintiffs here. Plaintiffs in fact appear to be attempting to make an end-run around the False Claims Act and its stringent limitations on unilateral exercise of injunctive control over payment or retention of federal funds.

The only reference to state regulation in Medicare is in the context of licensure requirements for physicians and facilities – there is no indication that Congress ever envisioned an independent enforcement role for the states, much less private litigants acting to further their own agenda. Medicare is a federal program administered by the federal government and subject to federal control, not the whims of individual litigants who happen to persuade a state court judge that federal regulations are inadequate or the federal government's decision with respect to payment of reimbursement in error.

D. This Case Properly Frames The Issues Presented, The Decision Of The California Court Has An Immediate, Adverse Impact On HMO Participation In Medicare And Any Delay In Resolving The Issues Will Lead To Further Detriment To The Federal Interest.

Plaintiffs assert that this Court should decline review because the decision of the California Court of Appeal concerning the availability of injunctive relief is "interlocutory" in nature. In sum, plaintiffs would have this

Court await issuance of an injunction directing the manner in which FHP markets its Medicare plan, as well as requiring refund of Medicare reimbursement paid with respect to these and other FHP members under the Medicare statutes. Plaintiffs' argument is unavailing for three reasons.

First, plaintiffs ignore the fact that an actual conflict already exists between the federal government's disposition of the purported claims of marketing improprieties by FHP employees and the relief sought by plaintiffs in their lawsuit. As noted in the petition, HCFA, after a thorough investigation, found no evidence of company *sanctioned* wrongdoing, took no action to limit FHP participation in Medicare and found refund of Medicare reimbursement to be neither necessary nor desirable.[2] In contrast, premised upon virtually identical evidence, plaintiffs are attempting to contradict HCFA's findings through maintenance of their action for injunctive relief. Thus, FHP faces future uncertainty with respect to marketing of its Medicare plan and, more critically, retention of Medicare reimbursement already paid by the federal government.

Moreover, the decision of the California Court of Appeal condoning unilateral actions for injunctive relief

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[2] Plaintiffs assert that HCFA's findings with respect to its investigation of FHP (Appendix to Pet., pp. 61-63) are somehow not part of the record. Opp., p. 21. Yet, plaintiffs themselves placed the information before the trial court, formally requesting the court to review a Los Angeles Times article reporting the results of the investigation. See Pet., p. 10; Los Angeles Times Dec. 24, 1991, Part D, p. D12. In addition, FHP's Senior Vice President David Engleberg recounted the text of the HCFA letter in his declaration in opposition to plaintiffs' motion to compel discovery, which was incorporated by reference in and heard concurrently with, the demurrer and motion for judgment on the pleadings raising the preemption issue. Pet., p. 10.

governing participation in a federal program necessarily creates immediate uncertainty with respect to HMO participation in Medicare. As previously noted, an HMO contemplating contracting with the federal government to provide services to Medicare beneficiaries has no means of knowing with certainty precisely who will have the final say with respect to determining its compliance with marketing standards and, more critically, its retention of Medicare reimbursement.

Finally, as this Court has recognized, questions concerning federal preemption of state court actions by private litigants are particularly suited to disposition on the pleadings where, as here, the issues are squarely presented. In *Chicago & Northwest Transportation Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311 (1981), an Iowa state court had dismissed a plaintiff shipper's damage action against a railroad arising from the railroad's abandonment of a right of way, concluding that the Interstate Commerce Commission possessed sole authority to determine penalties arising from abandonment of a rail line. The Iowa Court of Appeals reversed, finding no preemption, and the Iowa Supreme Court denied review. This Court granted certiorari and reversed the Iowa Court of Appeals, finding that the ICC regulations impliedly preempted any state common law action:

> "The decision below amounts to a holding that a state can impose sanctions upon a regulated carrier for doing that which only the Commission, acting pursuant to the will of Congress, has the power to declare unlawful or unreasonable. . . . It is difficult to escape the conclusion that the instant litigation represents little more than an attempt by a disappointed shipper to gain from the Iowa court the relief it was denied by the Commission." 450 U.S. at 324.

Here, too, the decision of the California Court of Appeal represents little more than a determination that plaintiffs may properly attempt to control and limit a defendant's participation in a federal program, including preventing receipt of federal funds that the federal government has found to be properly paid, simply as a means to provide additional redress with respect to their claims for fraud under state law. Whatever interest California has in preventing fraud through the imposition of tort liability in the form of a damage award, it most clearly cannot, without running afoul of the Supremacy Clause, grant individual litigants the power to control or terminate a defendant's participation in a federal program absent Congressional authorization to do so. The allegations of the complaint makes plaintiffs' intent and position all too clear. They seek to regulate the manner in which FHP participates in the Medicare contracting program and indeed to compel refund of Medicare reimbursement where the federal government has found refund to be neither necessary nor desirable. The result is an unprecedented invasion into an area of federal interest. Plainly, review is warranted.

CONCLUSION

For the foregoing reasons, petitioner respectfully submits that the petition for certiorari should be granted.

Dated: June 23, 1993.

Respectfully submitted,

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